

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. **378**
FILED JAN 16 1964

Primary Registration District No. **4552** Registrar's No. **73051138**

STATE FILE NUMBER

VS 300 Rev. 4/59	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF	DOCUMENT
1 114			
2 1140			
3			
4 1			
5 2			
6			
7 0			
8 0			
9 331x			
10			
11			
12 26-0			
13 2-0			
ITEM NO.	SHOULD READ	BY AFFIDAVIT OF	

USE BLACK INK

OR
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY WRIGHT		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY WRIGHT	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN MOUNTAIN GROVE		c. CITY OR TOWN MANSFIELD	
Length of stay in 1b 8 YRS.		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mtn. Grove Rest Home		d. STREET ADDRESS (If outside, give location) ---	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle Pool Last TURNER		4. DATE OF DEATH Month Dec Day 25 Year 1963	
5. SEX F	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-20-1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (City and state or country) Osark County Mo.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME ARCH B. HOWARD		13b. MOTHER'S MAIDEN NAME FANNIE McCallister	
14. NAME OF HUSBAND OR WIFE Lewis C. Turner		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. ---		17. INFORMANT Address HAROLD DENNIS Mansfield Mo	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 4 four days	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) --- DUE TO (c) ---		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) ---		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) ---	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20c. TIME OF INJURY Hour --- a.m. --- p.m. ---	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ---	20f. CITY, TOWN, OR LOCATION --- COUNTY --- STATE ---	
21. I attended the deceased from Dec. 18-1963 to Dec. 25-1963 and last saw her alive on Dec. 24-1963 Death occurred at --- on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE M. J. Kennedy M.D. (Degree or title)		22b. ADDRESS Mtn. Grove Mo.	
22c. DATE SIGNED Dec. 30/1963		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
23b. DATE Dec. 27, 1963		23c. NAME OF CEMETERY OR CREMATORY Hensley	
23d. LOCATION (City, town, or county) WRIGHT County Mo.		23e. DATE RECD. BY LOCAL REG. 1-4-1964	
24. FUNERAL DIRECTOR Max L. Miller Mansfield Mo		26. REGISTRAR'S SIGNATURE Bernice R. Silverman	

(Licensed Embalmer's Statement on Reverse Side)

96112001

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Max L. Miller

Licensed Embalmer No. 4720

P. O. Address Mansfield Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.